CRUROSCROTAL HERNIA.

AN ENTERO-EPIPLOCELE, WITH THE SPERMATIC CORD IN THE FEMORAL CANAL, THE TESTICLE IN THE SCROTUM AND AN ABSENCE OF THE INGUINAL CANAL.

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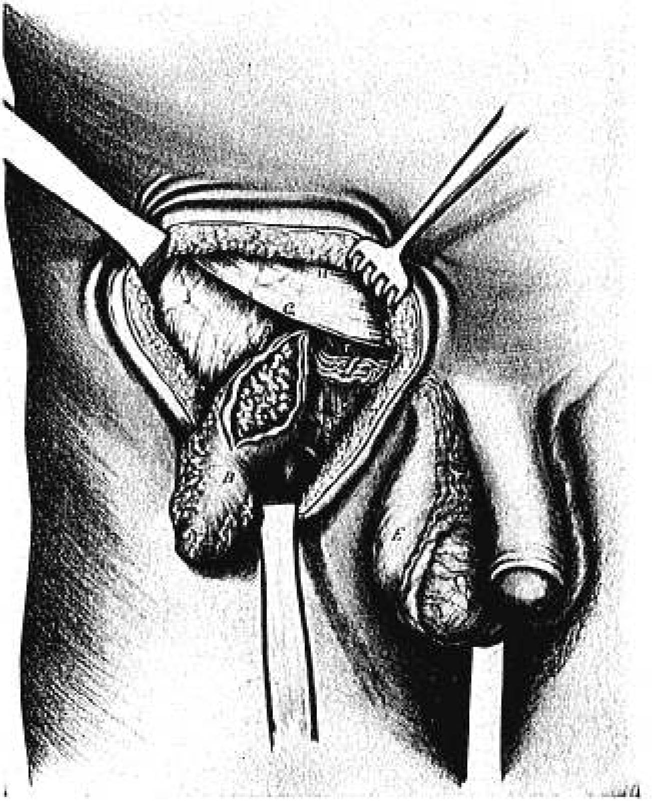
On the 23d of August, 1908, Dr. Mateer of Wooster, Ohio, accompanied Mr. H—— to the Chicago Hospital to consult me regarding an hernia. Mr. H—— complained that he suffered from an hernia in his right groin for 27 years, which he had never been able to control by a truss. The hernial region was painful and the truss hurt him. It was impossible to wear the truss constantly. He was conscious of a constant lameness and a tired feeling in his back, especially on the right side. When the hernia troubled him most he became incapacitated to perform his mental work,—as a teacher and manager of a large institution.

The mental depression was accompanied by a physical weakness which compelled him to lie down and rest.

If not careful of his diet he was inclined to be constipated. He dated his rupture to a time when he was 18 years of age, and was pitching hay on a farm. An extra effort was made with the pitchfork to heave the hay, when suddenly he felt something give way in his right groin and at once a tumor-like mass appeared in the scrotum. It has increased but slightly since its occurrence. The contents of the hernia could be reduced at any time, but in spite of appliances they would descend again into the scrotum.

With the exception of a severe burn he received during his last year in college, his general history was excellent. For several months after the burn he suffered from nervousness. There was nothing in the family history that bore upon his hernia.

Fig. 1.



Cruroscrotal hernia. *A*, femoral ring; *B*, sac; *C*, omentum; *D*, cord; *E*, bed of the sac; *F*, falciform ligament; *G*, Poupart's ligament; *H*, aponeurosis external oblique muscle; *I*, Gimbernat's ligament; *J*, pectineus muscle.

A physical examination revealed a man looking younger than his years, of a cheerful and buoyant disposition, complexion fair, eyes blue, squarely and stoutly built, in height fully 5 feet 8 inches, and weighing 185 pounds.

Upon examining the hernia it was found to recede into the abdomen with gentle manipulations while in the horizontal position, but just as soon as he stood on his feet the contents of the hernia protruded into the scrotum. The sac was irreducible. The cord could be traced to the femoral opening, and it was placed external to the pubic spine. The neck of the sac lay external and anterior to the cord and its fundus could be felt in the scrotum.

It was also perplexing to notice that no external ring could be made out. The diagnosis made was some strange variety of femoral hernia. In every other respect he was normal, even the left inguinal region.

Operative Findings.—Through a straight oblique incision over the mass, severing the skin, two layers of the superfascial fat between them and the root of the scrotum, the following structures were exposed: the aponeurosis of the external oblique, Poupart's ligaments, and the sac of the hernia.

The sac was found in the femoral canal and scrotum. Its enucleation was an easy matter. The cord was also in the crural canal and the testicle in the scrotum as represented in the accompanying drawing (Fig. 1). The sac was opened and found to contain a loop of small bowel easily reducible, and a mass of omentum extensively adherent to the posterior aspect of the sac and upwards as far as I could reach. It being impossible to deal with the omentum through the femoral opening I enlarged both it and the canal by cutting through all the fibrous structures parallel with and beneath Poupart's ligament, but in front of the great vessels, thus making a space large enough to allow the introduction of the sac, omentum, cord and testicle into the abdominal cavity. This being accomplished I made a new inguinal canal and placed the cord and testicle in their normal localities. It was, of course, necessary to split the fibres of the aponeurosis of the external oblique muscle, sever the attachment of the internal oblique at the internal aspect of Poupart's ligament, then push the testicle into the scrotum, and leaving the cord between the internal oblique and transversalis fascia overriding the deep epigastric vessels as in a normal inguinal region.

The red muscle (internal oblique) was attached the full length of Poupart's ligament.

The cremasteric muscle was absent and the oblique inguinal canal and its openings were not in existence. The patient being placed in the Trendelenburg position the omentum was detached and a portion of it amputated on account of the extent of its raw surface.

The sac was then ligated high up and removed. The operation was completed by suturing the transversalis fascia and the internal oblique muscle to Poupart's ligament in front of the cord, with interrupted sutures, repairing the wound in the aponeurosis of the external oblique with a continuous suture of fine chromic catgut and then closing the enlarged femoral opening by suturing the lower borders of Poupart's ligament to the pectineus muscle, internal to the vessels, and then closing the slit made in front of the vessels with a few interrupted sutures of catgut. The external wound was closed in the usual manner.